



1. A signed claim form from the Insured(s) Employer/Union is required for each calendar year and for each diagnosis.
2. The Recommendation of Authorization must be attached to your returned billing.
3. Complete the patient information in Section I.
4. Dates of service and number of sessions must correspond to the Recommendation of Authorization. Any dates of service not authorized cannot be billed. Please submit a Request for Treatment Authorization (Renewal) form *Attn: Utilization Review* to request authorization.
5. In Section II, include copayment and deductible(s) received, if applicable. Fill out your dates of services.
6. Late Cancellations and No-Shows cannot be charged to insurance.
7. Please have client sign the Authorization for Release of Information on the reverse side of this form.
8. Submit insurance billing *Attn: Claims Department*.

Section I

Employee: _____ Authorization Code: _____
 Social Security #: _____ DSM IV-R/IV Code: _____
 Patient: _____ Deductible: _____
 Employer: _____
 Therapist: _____ Signature: _____

Section II

Dates of Service Covered by Insurance

Dates of Service	Explanation of Services	Copayment Collected	Deductible Collected

Photocopy this form if authorization exceeds your monthly billing period.

Provider Office: Yes ____ No ____ Holman Office Location: _____